



PROVIDER REVIEW

Department of Economic Security, Comprehensive Medical and Dental Program

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"Claims and Prior
Authorization" Edition

Attention Providers Information Regarding the NICU Grad Program

Effective January 1, 2006, AHCCCS is implementing the NICU Grads program. The Governor's School Readiness Board Health Implementation Team determined that AHCCCS should implement a process to ensure that a formal developmental screen is conducted during primary care EPSDT visits to identify potential developmental delays of at-risk NICU graduates. Early intervention ensures children enter school with the highest potential for learning possible.

The Arizona Chapter of the Academy of Pediatrics (AzAAP) has collaborated with AHCCCS, through the Governor's School Readiness Board activities the Arizona Early Intervention Program (AZEIP), and the Arizona Department of Health Services (ADHS) Newborn Intensive Care Program (NICU) to implement a statewide developmental screening process. It was decided that Arizona will use the PEDS Tool (Parents' Assessment of Developmental Status, by Frances Glascoe), in this statewide initiative.

Effective January 1, 2006, providers can be reimbursed after performing the PEDS by using codes 96110 and 96111 after providing documentation of formal training in use of the PEDS Tool. Training is being coordinated through the Arizona Chapter of the Academy of Pediatrics (AAP). For information regard-

ing this training please contact, the AzAAP through their website www.azaap.org or by calling 602-532-0137. CMDP requirements for reimbursement of developmental screening are as follows:

- Completion of the PEDS training program;
- Copy of your certificate must be on file with CMDP (this should be submitted to the attention of Provider Services);
- Prior Authorization for these services is a requirement;
- At-risk infants discharged from the NICU are eligible for the PEDS developmental screening program; and
- Copies of the PEDS tools will need to be submitted in the same manner that the EPSDT forms are submitted with the CMS 1500 form.

AHCCCS has set the reimbursement for these two codes at \$29.60. As you are aware, CMDP is part of the State foster care system and by State Law we are required to reimburse at the AHCCCS fee schedule. CMDP appreciates your continue support in caring for Arizona's children in foster care. Should you have any questions, please contact your Provider Representative at CMDP (602) 351-2245.

EPSDT and Coordination of Services

EPSDT (well child visits) provide comprehensive health care through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for members under 21 years of age. EPSDT includes all medically necessary services to treat or improve any disorders, defects, or conditions identified in EPSDT screenings.

Comprehensive periodic screenings must be conducted according to the time frames in the AHCCCS Periodicity Schedules (refer to CMDP Provider Manual, Chapter 5 Appendix) and as appropriate for each member. Providers are responsible for rendering, or ensuring the provision of appropriate preventive and primary care services to the member. These services include, at a minimum:

- Treatment of routine illness
- Maternity services, if applicable
- Immunizations

- EPSDT screening for eligible members under age 21
- Medically necessary treatment for conditions identified in an EPSDT.

As part of the Arizona School Readiness Action Plan, AHCCCS and CMDP are working to increase well-child checkups, immunizations, dental visits and other important services. Diagnostic screenings for TB and Lead and subsequent follow-up ensure timely identification of problems and coordination of services.

Child health care professionals have unique opportunities to identify children with developmental and behavioral disorders, or those who are at risk of developing such problems, and to initiate appropriate interventions. Referrals to AZEIP and Head Start are important to identify risk factors and implement strategies to improve a child's chance at learning. Regular checkups for possible medical problems, vision and hearing screenings and preventive services such as immunizations against childhood diseases and dental care further ensure that children are healthy and able to focus on learning.





Implementing a Successful Developmental Screening Program

The first critical step to diagnosing and providing help for children with autism, developmental delays, learning problems, or other disabilities is for health care providers and early education providers to perform high-quality first-level developmental screenings on all children, not just those with suspected problems. The quality of screening instruments has improved dramatically in recent years, reflecting studies showing that guardian reports of skills and concerns about language, fine-motor, cognitive, and emotional-behavioral development are highly predictive of true problems. In addition to being highly accurate, parental-report tools have several advantages: they are relatively inexpensive, and the process of examination is relatively brief, from 2 to 15 minutes. Here are five concrete ways pediatricians can lead on this critical child health issue:

1. Upgrade your own practice to incorporate routine high-quality developmental screening, engaging front-office staff and nurses as key allies. For example, while many parents can fill out the simple and highly accurate forms on their own, some will need help because of literacy or language barriers. These common-sense and high-quality tools immediately catch 70 to 80 percent of children with problems.

2. Speak out, linking early identification and intervention to school readiness. PTA's, community groups, health agencies and local talk shows are perfect venues for the early-screening message, especially from a trusted local pediatrician. Communities concerned about student achievement should resonate to the message that *preschool-age* children with unidentified and unaddressed disabilities, delays and problems quickly become *school-age* children unprepared for success.

3. Encourage high-quality developmental screening in non-pediatric settings, such as child care and preschool programs. This will provide important information, community support, more informed parents and the best opportunity to

follow-up with children who have suspected problems.

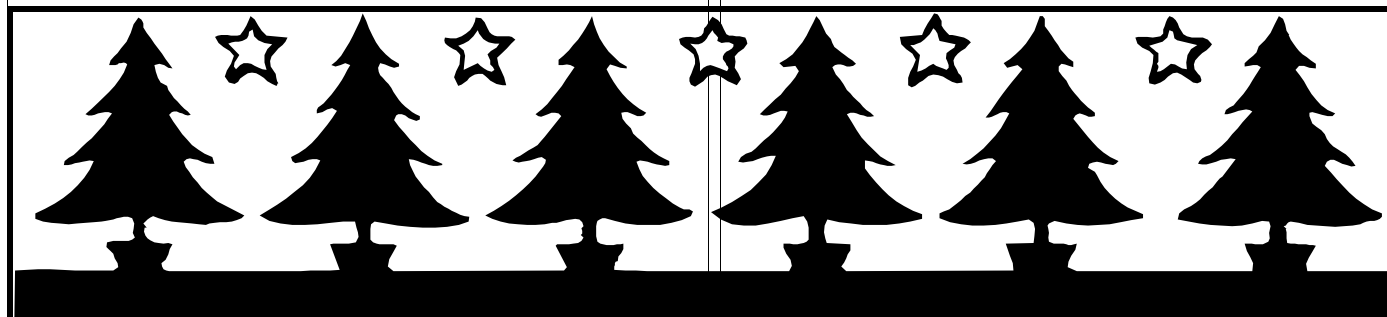
4. Engage professional colleagues as partners and leaders.

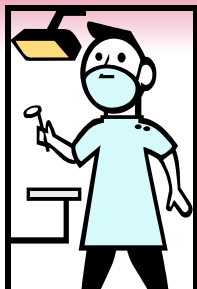
For example: "Part C" and IDEA for 3-5 year-olds (also known as "Part B, Section 619"). Just this year the federal Centers for Medicare and Medicaid Services

increased the value ("RVU" or "Relative Value Unit") for developmental screening (#96110). Yet this improvement has not resulted in widespread increased physician reimbursement for screening, and is unlikely that it will until medical groups press for this change.

5. Help the upcoming generation of pediatricians be prepared to do high-quality developmental screening. For example, does your medical school or residency placement provide training in such evidence-based tools as the PEDS, ASQ and CDI? Or are they still teaching the inferior Denver? You could also provide residents and interns with opportunities to conduct high-quality developmental screenings.

Pediatricians now have readily available standardized developmental screening tools that are practical and easy to use in the office setting. Successful early identification of developmental disabilities requires the pediatrician to understand screening techniques, actively seek the guardians concerns about development, and create links with available resources in the community.





DR C. says... “Maximum Protection for High Risk Individuals Professionally Applied Fluoride”

By Dr. Jerry Caniglia, CMDP Dental Consultant

All persons should drink water with optimal fluoride concentration as well as brush their teeth with fluoridated toothpaste. But for those individuals who are at high risk for dental decay, additional fluoride measure might be needed.

To have effective caries prevention, identifying and assessing individuals at risk for developing new carious lesions is essential. Although there are various methods for determining risk, no one particular model predominates. Individuals believed to be at increased risk for dental caries are generally those from low income populations, those who lack dental education and those who are unable to access regular dental services. The lack of dental insurance, private or public, plays a critical role in access to care. Professionally applied topical fluorides, which contain a high concentration of fluoride compounds, have been applied by dentists and dental hygienists for over 50 years in the United States. These

in-office fluorides and fluoride supplements should be prescribed to only those individuals at high-risk of developing caries, regardless of age. The most commonly used professionally applied topical agents are fluoride varnish, fluoride gel or foam, and in-office fluoride rinses. Research suggests that fluoride varnish and gel are equally effective in caries prevention. However, the risk of ingestion is less with a fluoride varnish and for this reason the varnish is preferable over the gel in children less than 6 years of age.

Fluoride continues to be the professional's best tool for the primary prevention of dental caries. Using topical fluoride products in an appropriate manner will significantly provide maximum protection, decrease the caries experience and improve the oral health of our communities.

Cultural Values and Beliefs

Health Care Providers should care for CMDP members without making judgments about the importance of one set of values over another. If your reaction is negative or devalues their concerns or problems (based on your own cultural system), their response may be to refuse health treatment.

The goal is to not let your own cultural values and beliefs interfere with providing quality health care. The difference between a provider who is culturally competent and one who is culturally aware is in the service that is provided. A culturally competent provider is aware of the cultural differences and even more aware of the individual and his or her personal needs.

Religious beliefs can also often influence decisions about medical treatment. Because of religious faiths, some caregivers may request diagnosis but not treatment. If a particular treatment is absolutely necessary, providers may find it helpful to consult with the family's spiritual leader. Families who seek mainstream medical care for CMDP members may also seek treatment from healers in their culture. Providers and their staff may want to incorporate traditional healing into the general treatment.

Menactra/GBS Alert

The FDA and CDC posted an alert for a possible connection between Menactra vaccine and Guillain-Barre Syndrome (GBS).

Five teens in four states developed GBS symptoms 2 to 4 weeks after receiving Menactra. All are recovering. While the rate is similar to that expected without vaccination, the timing is of concern and requires further investigation according to the FDA.

You may want to review the FDA alert at www.fda.gov/bbs/topics/NEWS/2005/NEW01238. MSNBC has posted an Associated Press release at www.msnbc.msn.com/id/9546850/print/1/displaymode/1098/.



If you become aware of any cases of GBS following Menactra, you are encourage to report them to the VAERS system at (800) 822-7967 or via the web at www.vaers.hhs.gov. The AAP will update information on the Member Center of our web site www.aap.org/moc, as it becomes available.



SL Modifier Required When Billing VFC Services

Providers who bill for administration of vaccines under the Federal Vaccines for Children (VFC) program must bill the appropriate CPT code for the immunization with the “SL” (State Supplied vaccine) modifier.

The Health Insurance Portability and Accountability Act (HIPAA) mandates standardization of codes by eliminating all local codes. This includes the standardization of modifiers. Providers had been billing for services under the VFC program using the AHCCCS-specific “VA” Modifier.

Providers were able to start using the “SL” modifier for date of services on and after October 1, 2003. Providers were required to bill with the “SL” modifier for dates of service on and after January 1, 2004. Claims billed with the “VA” modifier for dates of services on and after January 1, 2004 are denied. Under the VFC program providers are paid a capped fee for administration of vaccines to recipients 18 years of age and younger. Because the vaccine is made available to providers free of charge, they must not bill for the vaccine itself.

Providers must not use the immunization administration CPT codes 90471, 90472, 90473 and 90474 when billing under the VFC program.

Code	Description
	<u>Office Visit, Health History and Physical Examination</u>
99381	New patient, under 1 year
99382	New patient, 1 to 4 years
99383	New patient, 5 to 11 years
99384	New patient, 12 to 17 years
99385	New patient, 18 to 20 years
99391	Established patient, under 1 year
99392	Established patient, 1 to 4 years
99393	Established patient, 5 to 11 years
99394	Established patient, 12 to 17 years
99395	Established patient, 18 to 20 years
	<u>Counseling and/or Risk Factor Reduction Interventions</u>
99401	Approximately 15 minutes
	<u>Tests required by EPSDT Periodicity Schedule</u>
81000-81003	Urinalysis
83655	Lead
84030	PKU (<i>if not done in hospital</i>)
85013/85014	Hematocrit
85018	Hemoglobin
85027	Complete Blood Count
85660	Sickle Cell
86580	Tuberculosis (<i>Intradermal</i>)
86585	Tuberculosis (<i>Tine</i>)
92551	Hearing (<i>must be performed with calibrated machine</i>)





	<u>Immunizations</u>
90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule
90634	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule
90645	Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule)
90646	Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate, (3 dose schedule)
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule)
90655	Influenza virus vaccine, split virus, preservative free, 6-35 months dosage (covered under VFC only for high-risk children)
90656	Influenza virus Vaccine, split virus, preservative free, for the use of individuals 3 years and up, for intramuscular use
90657	Influenza virus vaccine, split virus, 6-35 months dosage (covered under VFC only for high-risk children)
90658	Influenza virus vaccine, split virus, 3 years and above (covered under VFC only for high-risk children)
90669	Pneumococcal conjugate vaccine, ployvalent, for children under 5 years
90700	Diphtheria, tetanus toxoids, and acellular pertussis (DtaP)
90701	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP)
90702	Diphtheria and tetanus toxoids (DT) adsorbed
90707	Measles, mumps and rubella virus vaccine (MMR)
90713	Poliovirus vaccine, inactivated (IPV)
90714	Tetanus and Diphtheria toxoids (Td) absorbed, preservative free, for use in individuals 7 years or older, for intramuscular use
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP) for use in individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine, live
90718	Tetanus and Diphtheria toxoids (Td)
90720	Diphtheria, tetanus toxoids and whole cell pertussis vaccine and hemophilus influenza b vaccine (DPT-Hib)
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and hemophilus influenza b vaccine (DtaP-Hib)
90723	Diphtheria, tetanus toxoids, and acellular pertussis vaccine, hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV)
90732	Pneumococcal Polysaccharide, 23 valent
90734	Meningococcal vaccine (meningitis vaccine) for use in individuals 11 years and older, for intramuscular use
90740	Hepatitis B Vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule)
	Hepatitis B Vaccine, adolescent (2 dose schedule)
90743	Hepatitis B, pediatric/adolescent dosage (3 dose schedule)
90744	Hepatitis B, dialysis or immunosuppressed patient dosage (4 dose schedule)
90747	Hepatitis B and hemophilus influenza b (HepB-Hib)
90748	

Prevent Serious Secondary Infections

The Comprehensive Medical and Dental Program (CMDP) is asking for your help in preventing serious secondary infections from influenza in Arizona by encouraging you to immunize high-risk patients against pneumococcal diseases.

Infections with bacterial pathogens, such as *Streptococcus pneumoniae*, are the main cause of severe illness and death from influenza among high-risk persons in Arizona. Administering pneumococcal vaccine to high-risk groups can significantly reduce secondary infections and reduce illness and death from influenza. Increasing pneumococcal vaccine coverage among high-risk groups will reduce the public health impact from influenza during the annual flu season, as well as reduce the impact of secondary infections during an influenza pandemic. We believe that this measure is a simple, practical, and effective way of improving our public health preparedness.

Equal Opportunity Employer/Program This document available in alternative formats by contacting Provider Services.

CLAIMS:
For verification of claim status, please ask the operator for a claims representative.

Susan Stephens, M.D., Medical Director.....ext 7065
Mary Ferrero, R.N., Medical Services Manager.....ext 7070
Hospitalizations.....ext 7116
EPSDT.....ext 7063
Prior Authorizationsext 7065
Behavioral Health.....ext 7009 / 7060
Social Services.....ext 7073
**Please contact Medical Services with any questions regarding the
medical needs of our members.**

PRIOR AUTHORIZATION

The provider requesting the service (e.g., physician, therapist, vendor) completes the appropriate prior authorization form and mails or faxes to CMDP, along with documentation of medical necessity.

The following information **must** be submitted by the provider for the PA form to be complete:

- Name, date of birth and ID Number of the member
- Name, address and phone number of the provider
- Service being requested
- Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) codes
- Diagnosis
- Date of service
- Medical record documentation substantiating medical necessity, provider signature present on the PA form, prescription or attached documentation and
- Any additional information necessary to substantiate medical necessity.

The PCP must forward documentation to the receiving specialist to substantiate the referral. The specialist must be registered with AHCCCS and CMDP. Initial evaluations do not require prior authorization from CMDP, however the primary care provider must document why the referral is requested and a script must be forwarded to the specialist. Treatment or continued services do require prior authorization. Additional documentation may be requested to substantiate medical necessity.

If you have any questions regarding the PA process or would like a copy of the CMDP Prior Authorization Form, please contact Medical Services, or refer to the CMDP Provider Manual Chapter 5.

